

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-014378

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1189

FILED APR 11 1963

|   |                           |   |                                  |
|---|---------------------------|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST. LOUIS</u> 25  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>IOWA</u> b. COUNTY                                     |                                  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>LE MAY</u>  |                           | c. CITY OR TOWN <u>FORT MADISON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                       |                                  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>320 EAST RIPA AVENUE</u>  |                           | d. STREET ADDRESS (If outside, give location)<br><u>2204 Avenue I</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>    |                                  |
| 3. NAME OF DECEASED<br>(Type or print) <u>SISTER MARILYN ROTH</u>   |                           | 4. DATE OF DEATH <u>APRIL 6, 1963</u>   |                                  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/27/09</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>TEACHER</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |                                  |
| 11a. FATHER'S NAME<br><u>PHILIP ROTH</u>  |                           | 11b. MOTHER'S MAIDEN NAME<br><u>APPLE BAUM</u>  |                                  |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)   |                           | 13. SOCIAL SECURITY NO. <u>[REDACTED]</u>   |                                  |
| 14. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u><br>DUE TO (b) <u>[REDACTED]</u><br>DUE TO (c) <u>[REDACTED]</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>[REDACTED]</u> |                           | 15. INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr.</u>  |                                  |
| 16. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           | 17. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |                                  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |                                  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                           | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                  |
| 20f. CITY, TOWN, OR LOCATION  |                           | COUNTY STATE  |                                  |
| 21. I attended the deceased from <u>Oct 1962</u> to <u>Apr 1963</u> and last saw her alive on <u>Apr 2, 1963</u><br>Death occurred at <u>11 45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |                           |   |                                  |
| 22a. SIGNATURE (Degree or title)<br><u>Sergey F. Ortmeier MD</u>  |                           | 22b. ADDRESS<br><u>2023 Telegraph Rd</u>  |                                  |
| 22c. DATE SIGNED<br><u>Apr 8, 1963</u>  |                           |   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                           | 23b. DATE<br><u>4/9/63</u>  |                                  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>CONVENT CEMETERY</u>   |                           | 23d. LOCATION (City, town, or county)<br><u>320 EAST RIPA, ST. LOUIS, MISSOURI</u>  |                                  |
| 24. FUNERAL DIRECTOR<br><u>Thomas Kutz</u>  |                           | 25. DATE RECD. BY LOCAL REG.<br><u>4-8-63</u>   |                                  |
| 26. REGISTRAR'S SIGNATURE<br><u>John B. Murphy</u>  |                           |   |                                  |

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Mr. Antinegin  
Dec 7, 1910  
2023 Telley.  
Kingsdon Mr

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John A. Humphrey*

Licensed Embalmer No.

*4772*

P. O. Address

*2906 Graves*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

1-3 PM